Medicare, Medicaid and the Deficit Debate

Timely Analysis of Immediate Health Policy Issues

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Executive Summary

The U.S. has been engaged in an ongoing debate over the size of the federal deficit, a debate that is likely to continue through the 2012 presidential election and beyond. Medicare and Medicaid spending are a major part of this debate. Some have called for a significant restructuring of both programs—premium support for Medicare and block grants for Medicaid—on the grounds that costs are "out of control." Reform proposals focus on reducing the rate of growth in spending in both programs to a rate close to the increase in economic growth. In this paper we show that spending in both programs has been significantly affected by enrollment growth, but that both the Centers for Medicare and Medicaid Services (CMS) and the Congressional Budget Office (CBO) project spending growth per enrollee in both programs to be less than private insurance expenditures and to be close to the growth in gross domestic product (GDP) per capita.

We show that health expenditures in the last decade (2000-2010) grew about three percentage points faster per year than the growth in GDP. The rate of increase in health spending for private insurance as well as both public programs, quite high in the beginning of the decade, slowed considerably in the later years, but so did the growth in GDP because of the Great Recession. Thus, increases in health spending remained well above the growth in GDP.

Between 2011 and 2020 both CMS and CBO project health expenditures to slow considerably relative to GDP growth. In part this reflects faster GDP growth than seen at the end of the last decade. But it also seems to reflect greater cost sharing in private insurance, Medicare payment policies, slowing prescription drug spending growth and the excise tax (2018) on high cost insurance premiums.

Between 2000 and 2010, Medicare spending grew as fast as or faster than increases in private expenditures. But Medicare enrollment increased while private health insurance coverage fell. On a per enrollee basis, expenditure growth in Medicare was slightly below that of private insurance.

Over the next decade, both private health expenditures and Medicare are projected to grow at about the same rate (5.7 and 5.8 percent per year respectively). But Medicare enrollment will grow much more than private coverage because of the aging of baby boomers. Private health insurance spending per enrollee is projected to increase by 4.9 percent per year, about the same as the end of the previous decade. Medicare expenditures per enrollee are expected to increase by only 2.7 percent per year largely because of the cuts in provider payments in the Affordable Care Act.

The rate of increase in Medicaid expenditures also declined over the last decade. A major contributor to Medicaid expenditure growth has been increases in enrollment caused by the two economic recessions experienced in the past decade and continued growth, almost 3 percent per year, in the disabled population. Medicaid spending growth on a per enrollee basis in the past decade was below 3 percent per year. Part of this relatively low growth rate is due to the changing composition of Medicaid enrollees— the number of lower cost adults and children grew faster than the aged and disabled. But states have also been very aggressive in cost containment efforts because they face declining revenues and have many competing priorities.

Between 2011 and 2020 overall Medicaid expenditures are projected to grow at 8.7 percent per year by the CMS actuaries and 8.1 percent per year by CBO. Increases in overall Medicaid spending will continue to be driven by enrollment growth largely because of the Affordable Care Act. Both CMS and CBO project growth in spending per Medicaid enrollee to be slightly above 4 percent per year, only marginally faster than the projected growth in GDP per capita.

We conclude that spending growth in Medicare and Medicaid is greatly affected by enrollment and on a per enrollee basis is projected to be close to the rate of growth in GDP per capita in the coming decade. Thus, spending growth in both programs on a per enrollee basis is not "out of control" and is close to the target often advocated by those concerned with the nation's deficit. But part of the budget problem the nation faces is the combined effect of growth in enrollment and spending per enrollee. Thus it is important to explore proposals that would lower overall spending in both programs. Many of these have been proposed by the National Commission on Fiscal Responsibility and Reform (Bowles-Simpson) as well as others. We discuss several of these below.

The evidence that much of the perceived spending problem is driven by enrollment growth and the continued projection of modest growth in spending per enrollee suggests that proposals such as premium support and block grant proposals will have a hard time achieving better outcomes. While both approaches may achieve savings for the federal government, the evidence suggests that they can do so primarily by shifting Medicare costs onto existing enrollees and in the case of Medicaid onto the states as well.

Urban Institute

Introduction

The year 2011 was marked by fierce debate over the federal deficit, sparked by the need to increase the debt ceiling. The Budget Control Act and its sequestration provisions ensure that the deficit debate will continue throughout the 2012 presidential campaign and beyond. Solving the nation's fiscal problems will require decisions on the extension of the Bush tax policies, as well as cuts in discretionary domestic and defense spending and entitlement program expenditures. Along with Social Security, Medicare and Medicaid are often prominent targets of proposals to reduce the federal deficit. In this paper, we present data on recent Medicare and Medicaid spending growth and consider the prospects for slowing this growth in the future.

The National Commission on Fiscal Responsibility and Reform (Bowles-Simpson) proposed several options for reducing spending in Medicare and Medicaid. These included changes to the current programs, such as reforms to Medicare cost-sharing provisions, raising the Medicare eligibility age, and placing dual eligibles in managed care programs.[1] Other proposals for entitlement reform, however, envision more fundamental restructuring of Medicare and Medicaid. Chairman of the House Budget Committee Paul Ryan has called for some version of a Medicare premium support program (providing stronger incentives for beneficiaries to enroll in private insurance plans) and a Medicaid block grant, positions that have been endorsed by the leading Republican presidential candidates.[2] Supporters of these proposals argue that major changes to the existing programs are the only way to achieve sustainable levels of spending in Medicare and Medicaid, while opponents believe that such policies will have little effect on growth and merely shift the spending burden from the federal government to beneficiaries and states.

In an effort to ground the debate over entitlement reform, this paper examines the growth in spending on Medicare and Medicaid over the last decade and projections for the next decade. We find that spending in both programs has been driven to a great extent by enrollment growth, though for different reasons, and that growth in spending on a per enrollee basis has been below that of private insurance plans. Various proposals for addressing Medicare and Medicaid spending call for limiting per enrollee spending growth to gross domestic product (GDP) per capita or slightly higher.[3] We show that both the Centers for Medicare and Medicaid Services (CMS) and Congressional Budget Office (CBO) now project per enrollee spending in both programs to grow at close to (or below) the rate of growth in GDP per capita over the next decade. These findings suggest a need for continued vigilance in monitoring Medicare and Medicaid spending growth, but do not support an argument for major restructuring of the two programs. Arguably, the levels of spending, not just the growth rates, are too high, suggesting that more can be done in both programs. We therefore include recommendations for further spending restraint.

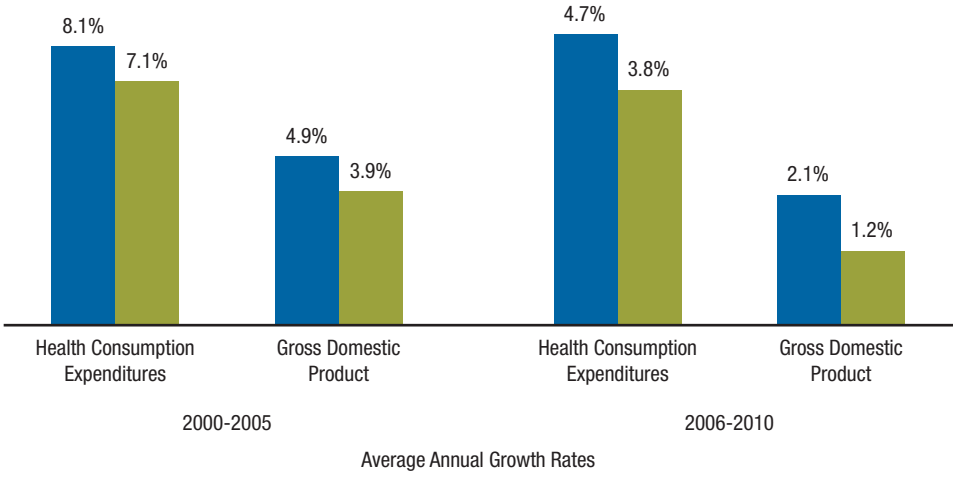
Data and Methods

We obtain historic estimates of aggregate health expenditures, by payer and service, from the CMS Office of the Actuary (OACT) from 2000 through 2010.[4] We also obtain projections of health spending for the period 2011–2020 from both CMS OACT and CBO.[5] We present estimates for total health consumption expenditures, as well as estimates for Medicare, Medicaid, and private health insurance. We also show the growth in enrollment within each insurance category and generate per enrollee spending estimates by dividing spending by enrollment for each payer in each year.[6] We present the average annual growth rates between 2000 and 2005, 2006 and 2010, and 2011 and 2020. We ignore the growth between 2005 and 2006 because the introduction of Medicare Part D shifted prescription drug expenditures for dual eligibles from Medicaid to Medicare and also shifted significant drug spending from private Medigap insurance to Medicare. Average annual growth rates are presented in Figures throughout the text. Supplemental tables including the complete spending and enrollment estimates for each decade are available in the appendix.

Health Consumption Expenditures, 2000–2010

In this section we examine total health consumption expenditures over the entire decade, 2000–2010, using data from the CMS OACT.[7] Figure 1 shows that in the first part of the decade (2000–2005), overall health expenditures increased by about 8 percent per year, while spending per person increased by about 7 percent. Spending slowed down in the latter half of the decade, however, and this slowdown has received relatively little attention. Between 2006 and 2010, overall spending grew at 4.7 percent per year and spending per capita grew by 3.8 percent.

Figure 1: Health Consumption Expenditure and GDP Growth, 2000-2010



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, January 2012.

The slowdown appears to have begun as early as 2004 and continued throughout the remainder of the decade (appendix table 1). Slow growth since 2007 has been attributed, no doubt correctly, to the deep recession and the loss of jobs and reductions in incomes and private health insurance.[8] Given that spending began to slow well before 2007, however, not all of the expenditure growth decline can be attributed to the recession. Some may be due to movement to private insurance arrangements with higher deductibles and tiered products. But Medicare spending growth also slowed, without adopting higher cost-sharing or changes in Medigap coverage, and thus the lower growth rates experienced by all payers are likely due to structural changes that are not well understood.

It seems that after a spike in spending growth from 2000 to 2002, several factors have contributed to slower health spending growth beginning in 2004.[9] Prescription drug spending growth, a major driver of total spending growth in the nineties, fell substantially due to fewer blockbuster drugs, adoption of tiered formularies, and increases in generic substitution and over-the-counter alternatives. The expiration of provisions of the Balanced Budget Refinement Act and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act, which had temporarily increased Medicare rates for hospitals and nursing homes, led to slower growth in Medicare spending on these services. The Medicare Payment Advisory Commission (MedPAC) has also shown that the growth in the volume of Medicare inpatient services declined by 1 percent per year between 2004 and 2010.[10] Other contributors to slower growth included a deceleration in the growth of administrative costs associated with private health insurance, as well as cost containment efforts by state Medicaid programs. A number of delivery system changes (e.g., more clinical integration and increases in salaried physicians) may also have contributed.[11]

Private Health Insurance and Medicare Expenditures, 2000–2010

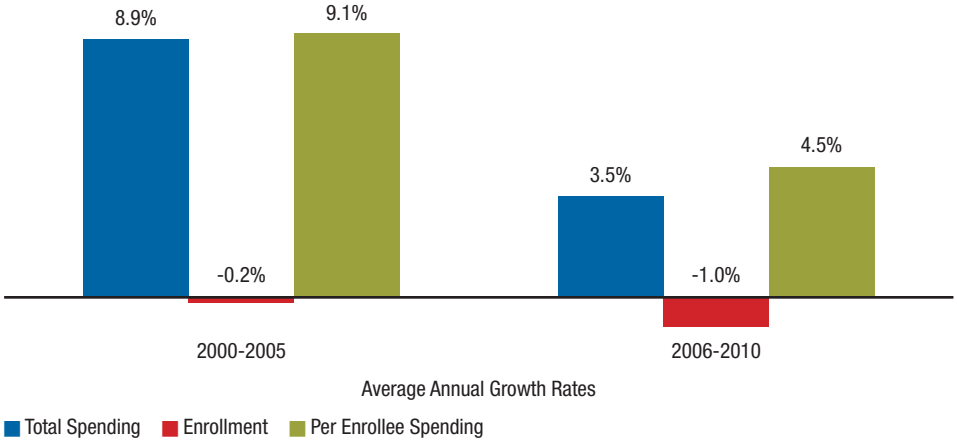
The growth in private health insurance expenditures clearly declined over the decade (Figure 2), both because fewer people had private health insurance but also because of a decline in per enrollee spending, beginning as early as 2004.

Overall, average annual spending growth declined from 8.9 percent between 2000 and 2005 to 3.5 percent between 2006 and 2010. On a per enrollee basis, spending growth declined from 9.1 percent in the first half of the decade to 4.5 percent in the latter half. Growth in spending per enrollee is greater than the increase in overall spending because of the decline in the numbers covered by private insurance.

Medicare spending growth also declined over the same period (Figure 3). Medicare spending grew at 8.6 percent between 2000 and 2005, comparable to private health insurance spending, and by 6.8 percent between 2006 and 2010. Overall spending growth rates in Medicare are higher than those in private health insurance, but this is solely due to the fact that Medicare enrollment has been increasing and the number of people with private insurance has been declining. Medicare enrollment grew at an average rate of 1.3 percent per year from 2000 through 2005 and at 2.5 percent from 2006 through 2010 (Figure 3).[12]

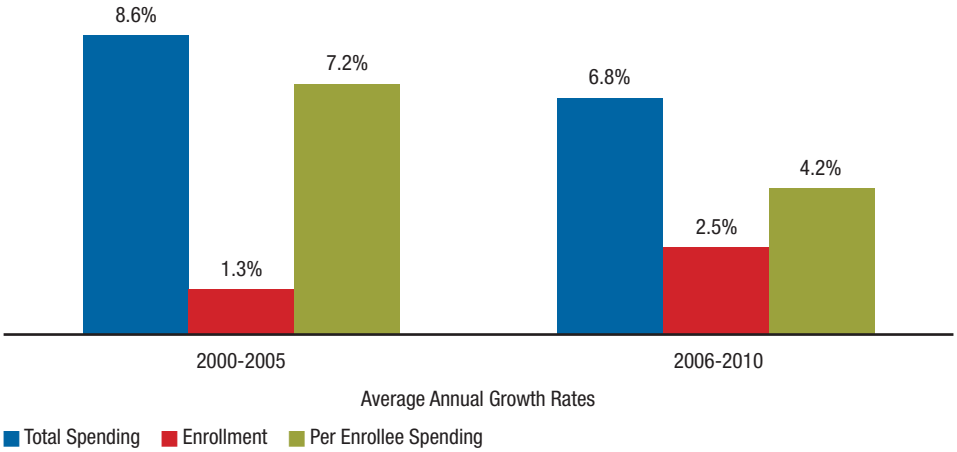
This pattern is also reflected in enrollment in Parts A, B and D (data not shown).[13] Enrollment in Part A grew at 1.4 percent per year in the first half of the decade and 2.3 percent in the latter part, reflecting the early effects of population aging—

Figure 2: Private Insurance Expenditure and Enrollment Growth, 2000-2010



Sources: Centers for Medicare and Medicaid Services, Office of the Actuary, January 2012; Current Population Survey 2000-2010.

Figure 3: Medicare Expenditure and Enrollment Growth, 2000-2010



Sources: Centers for Medicare and Medicaid Services, Office of the Actuary, January 2012. CMS Part A and Part B enrollment reports and Part D contract and enrollment summary reports.

even before beneficiaries reach the age of 65, disability rates increase and affect Medicare enrollment.[14] Part B enrollment growth was similar, 1.2 percent and 2.0 percent, respectively. Part D enrollment was 24.3 million in 2006, its first year, and increased to 29.8 million in 2010, for an average annual increase of 5.3 percent. Overall, Medicare spending growth declined on a per enrollee basis from 7.2 percent in the first half of the decade to 4.2 percent in the latter part (Figure 3).

In both periods, Medicare spending growth rates on a per enrollee basis were below those of private health insurance, by 1.9 and 0.3 percentage points in the first and latter parts of the decade, respectively. Earlier research found similar differences.[15] The Medicare per enrollee growth rate in the first part of the decade exceeded the increases in GDP per capita by 3.3 percentage points and in the second half by 3.0 percentage points. Medicare expenditure growth slowed, but so did GDP, because of the recession beginning in 2007. Growth in per enrollee expenditures in private insurance exceeded GDP growth by even more, 5.2 and 3.3 percentage points in the first and second halves of the decade, respectively.

Health Consumption Expenditures, 2011–2020

Figure 4 shows projected health expenditures over the next decade, 2011–2020. Overall health consumption expenditures are projected to increase annually by 6.1 percent. Per capita health consumption expenditures are projected to increase by 5.2 percent per year, with the difference due to population growth.

The projected rate of increase in health expenditures is 1.3 percentage points faster than projected GDP growth, less of a differential than seen in the previous decade. The report by CMS actuaries suggests a number of factors that may contribute to slower increases in health spending relative to GDP growth.[16] One is that health spending had slowed late in the past decade and projections are for similar rates over the next decade. Further, the GDP growth is substantially faster, reflecting a return to a more normal rate of growth. In addition, they mention higher cost-sharing in private insurance plans; Medicare policies that reduce payments to providers; a shift of coverage from some employers into coverage through exchanges, which are expected to be less expensive; an excise tax on high-cost private insurance plans in 2018, which should reduce the comprehensiveness of coverage; and a lower rate of growth in spending on prescription drugs.

Private Health Insurance and Medicare Expenditures, 2011–2020

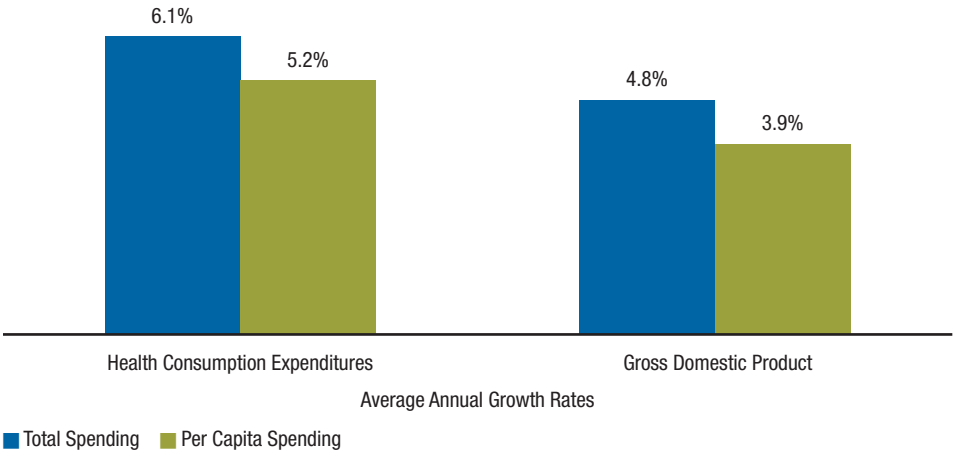
Private health insurance spending is projected to increase by 5.7 percent annually over the 10-year period (Figure 5). The CMS actuaries project increases in private health insurance coverage, mostly around the time of the implementation of the Affordable Care Act (ACA). On average over the decade, enrollment is expected to increase by 0.8 percent per year. On a per enrollee basis, private health insurance spending is therefore projected to increase by 4.9 percent, about 1.0 percentage point faster than the growth in GDP per capita (3.9 percent) over the same period. The 4.9 percent growth rate is only slightly above the rate experienced at the end of the previous decade (4.5 percent).

The CMS actuaries project Medicare spending growth of 5.8 percent per year between 2011 and 2020 (Figure 5), about 1 percentage point faster than the growth in the U.S. economy (4.8 percent per year). If physician fees were allowed to increase with the Medicare Economic Index (MEI) rather than face large cuts, Medicare spending growth would increase about 0.9 percentage points faster, or 6.7 percent per year.[17] MedPAC has recently recommended an overall freeze in rates with small reductions for nonprimary care physicians—this is a more likely policy outcome and would have less of a cost impact.[18] A principal reason for the 5.8 percent (or somewhat higher) projected rate of growth in Medicare is the substantial increase in enrollment of baby boomers who began turning 65 in 2011. Medicare enrollment is projected to grow by about 3 percent per year over the decade.

Figure 5 (appendix table 2) shows that Medicare spending growth on a per enrollee basis is projected to be 2.7 percent per year (somewhat higher with a freeze on annual physician fee increases—a freeze increases annual growth relative to current law), which is slower than the projected increase in GDP per capita (3.9 percent) over the same period. This suggests that doing better than the current projections may be quite difficult, though, as we suggest below, there are ways of reducing Medicare spending further. As noted, spending growth per enrollee for the privately insured is expected to average 4.9 percent per year, well above that of Medicare and above annual per capita GDP growth.

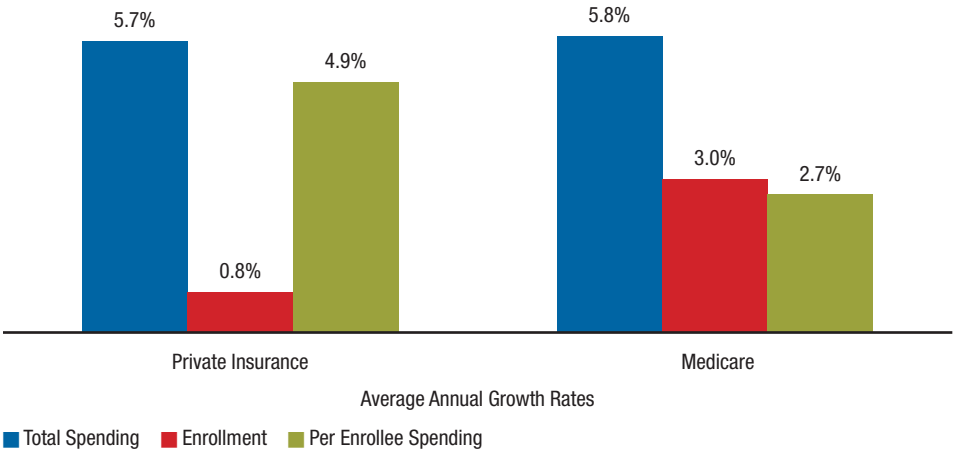
Some of the slower trend projected in Medicare spending per enrollee is due to low general inflation and the changing

Figure 4: Health Consumption Expenditure and GDP Projections, 2011-2020



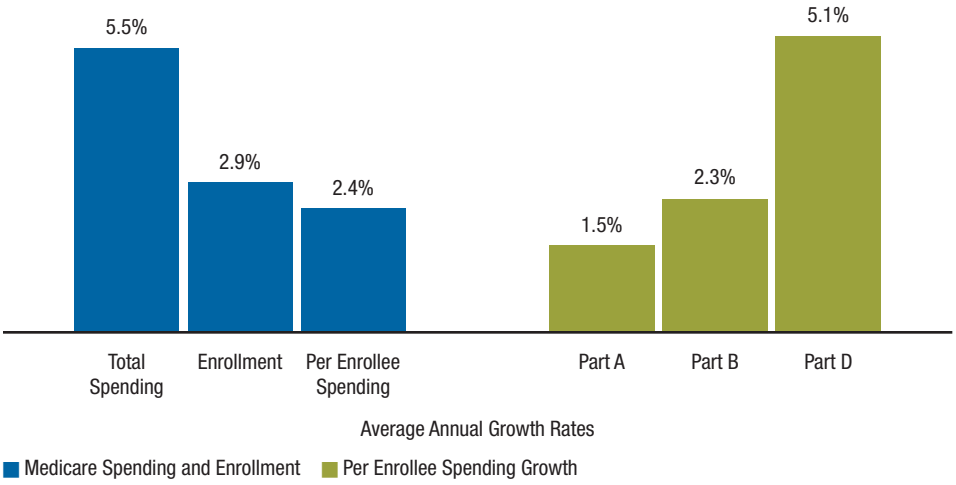
Source: Centers for Medicare and Medicaid Services, Office of the Actuary, August 2011.

Figure 5: Private Insurance and Medicare Expenditure and Enrollment Projections, 2011-2020



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, August 2011.

Figure 6: CBO Medicare Spending and Enrollment Projections, 2011-2020



Source: Congressional Budget Office March 2012 Medicare Baseline.

composition of the population. The growth of the population in the lower cost, 65- to 75-year-old group brings down the average cost of a Medicare enrollee, which explains a small part of the slowing spending growth.[19] The slow growth, by historical standards, in spending per enrollee is mostly due to provisions in the ACA that are expected to reduce Medicare spending. These provisions have reduced payments to Medicare Advantage plans, hospitals, skilled nursing facilities, and home health services. The CMS actuaries estimate that these provisions have reduced the projected Medicare spending growth rate by more than 1 percentage point.[20] As noted, however, a fix to the sustainable growth rate (SGR) formula that increases physician fees by medical inflation minus a productivity factor will increase Medicare spending growth by about 0.9 percent per year.[21] Other proposals, such as freezing rates rather than permitting severe reductions, would result in a much smaller increase. There are many reasons to support a change in the SGR policy, and the current projections indicate that it would still leave Medicare spending growth on a per enrollee basis below the rate of growth in GDP per capita. There are also several ways the higher costs of replacing the SGR could be offset.[22]

Figure 6 shows that CBO projections are quite similar to those generated by CMS. Overall, CBO projects the growth in Medicare benefits to be 5.5 percent per year, with increases of 4.5 percent for Part A, 5.4 percent for Part B, and 9.0 percent for Part D (appendix table 3). CBO does not provide an independent estimate of the effect of the fix to the SGR. Presumably it would increase overall growth rates, but by how much depends on whether fees are frozen or allowed to increase, and on offsets. Overall, enrollment growth is projected to be 2.9 percent per year (Figure 6), with increases of 3.0 percent for Part A, 2.9 percent for Part B, and 3.7 percent for Part D (appendix table 3). The end result is a projected increase in overall spending per enrollee of 2.4 percent per year, with increases of 1.5 percent for Part A, 2.3 percent for Part B, and 5.1 percent for Part D (Figure 6). The slow growth in Part A reflects primarily provisions of the ACA; Part B growth would be higher with an SGR fix. Some of the modest growth is due to low inflation and change in the composition of the elderly population, but the primary reason is the impact of the Medicare provisions enacted as part of the ACA.

Is the Slow Projected Medicare Growth Rate Feasible?

Some, including the CMS actuaries, have argued that the cuts in Medicare spending are not sustainable, particularly for hospitals, because Medicare payments will not keep up with the growth in the costs of hospitals and other health care providers.[23] CMS projections (not shown) indicate that Medicare spending per enrollee on hospital care will increase by 3.2 percent per year, thus clearly not falling. But if this growth does not keep up with increases in hospital costs, it is argued that there will be pressure to increase Medicare payment rates. If this is true, these current growth rate projections will prove to be too optimistic. This may well be true, particularly with the projections of much faster growth in private spending, but there are also good reasons to believe the Medicare forecasts will be realized.

The argument against sustainability of payment reductions suggests that hospitals have no choice but to incur these costs, and that faced with revenue constraints, they will not take steps

to reduce the rate of growth in their spending. Some also argue that hospitals would respond to lower revenues from public payers by increasing costs to private payers and that the differential between private and Medicare rates will reduce access, eventually creating political pressure for rate increases above those in these projections. The issue of provider responses to Medicare rate reductions is a matter of considerable debate, however.

Recent evidence suggests that hospitals cannot increase charges to private payers in all markets.[24] That is, hospitals that have considerable market power can increase charges to private payers. In contrast, hospitals in competitive markets are more likely to control costs. In general, the literature suggests that the ability to cost shift exists, particularly in concentrated markets, but that rate reductions generally, but not always, force hospitals to lower their costs.[25] MedPAC has shown that hospitals with relatively small commercial market share have less ability to increase private rates. As a result, they constrain cost growth and generally have positive Medicare margins. Hospitals with stronger market power are able to increase charges to private payers; they face less pressure to contain the costs and have higher cost per unit of service.[26,27] Other studies have concluded that cost shifting can occur but that it is limited. One estimate is that providers shift 21 cents per each dollar lost on Medicare.[28] This implies that they cannot or do not shift the other 79 cents and thus do more to control their costs. The bottom line is that rate reductions generally, but not always, lead hospitals to limit cost growth.

It is also important to note that the argument that Medicare cuts are not sustainable is the same as the argument that it is impossible to control health care costs through any other mechanism (e.g., higher cost-sharing, delivery system reforms, and so on). All would lead to lower provider revenues and force a provider response. Thus, there is a credible argument that the Medicare cuts are sustainable.

To summarize:

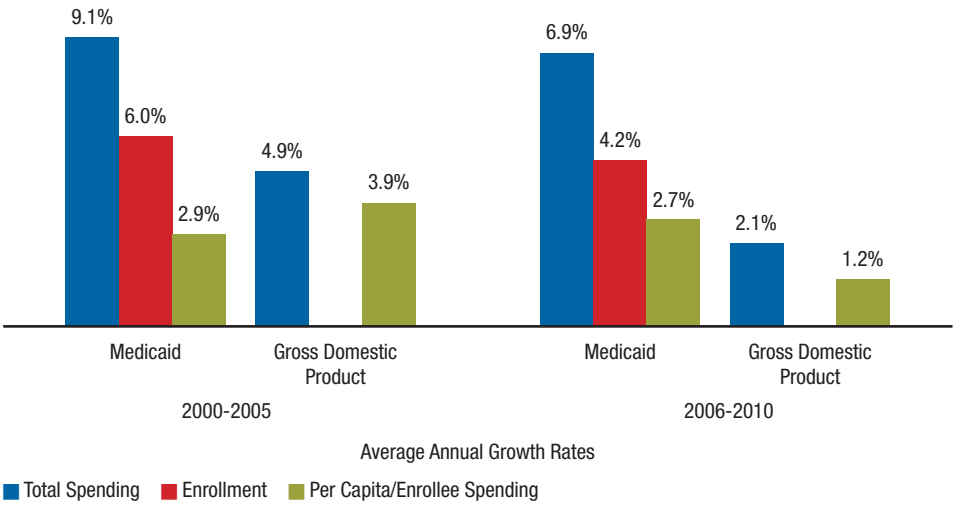
- Health spending in the last decade grew about 3 percentage points faster per year than the growth in GDP. The rate of increase in health spending fell substantially over the decade but was still well above the growth in GDP.
- Growth in private health expenditures declined over the decade; enrollment in private plans fell, but per enrollee expenditures increased by 4.5 percent per year in the latter part of the decade, considerably faster than growth in GDP per capita.
- Medicare spending growth also slowed over the decade. Spending per enrollee increased at a slightly lower rate than private spending—4.2 percent per year compared to 4.5 percent. Faster enrollment growth, because of demographic factors, resulted in overall Medicare spending growing faster than private insurance spending.
- Over the next decade, both private health insurance expenditures and Medicare are projected to grow at about the same rate (5.7–5.8 percent per year).
- But Medicare enrollment will grow much more than private coverage. Private health insurance spending per enrollee is projected to increase by 4.9 percent per year; Medicare expenditures per enrollee are expected to increase by only 2.7 percent per year.
- The low rate of projected per enrollee expenditures in Medicare primarily reflects cuts in provider payments in the Affordable Care Act.

Medicaid Expenditures, 2000–2010

Figure 7 shows the growth in Medicaid spending from 2000 to 2010 based on data from the CMS actuaries. Again, we look at Medicaid expenditures before and after 2006 because of the transition of Medicaid drug benefits for dual eligibles to Medicare. In the first half of the decade (2000–2005), Medicaid spending grew by 9.1 percent per year, and in the latter half (2006–2010) by 6.9 percent per year. Medicaid enrollment has grown rapidly over the past decade, however, because of the two economic recessions. Enrollment growth was 6.0 percent during the first half and 4.2 percent in the latter half. Enrollment in Medicaid grew rapidly in the first half of the decade because of the recession that occurred between 2000 and 2002, with effects that continued beyond 2002. In the middle part of the decade the enrollment growth was relatively flat, but then spiked in 2009 and 2010 because of the Great Recession.

Medicaid enrollment growth has been driven by several factors. There have been increases in eligibility levels in some states, but as we have shown elsewhere, there has also been a substantial increase in the size of the low-income population. This increase was significant during the recession of the first part of the decade, slowed slightly during the middle period of moderate economic growth, and

Figure 7: Medicaid Expenditure and Enrollment Growth, 2000-2010



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, January 2012.

then increased again between 2007 and 2010. All of the net increase in the U.S. population between 2000 and 2010 was among those with incomes below 200 percent of the federal poverty level.[29] The increase in the number of low-income people, particularly those in poverty, has led directly to increases in Medicaid rolls.

There has also been an increase in the aged and disabled population.[30] The growth in this population has been due in part to the aging of the baby boom generation; as individuals reach the age of about 50, the likelihood of disabilities increases. There are also new technologies that sustain life but often with ongoing disabilities, as well as increased recognition and treatment of chronic illnesses, particularly mental illness. The treatment of HIV/AIDS patients with prescription drugs has also preserved lives but has added to the rolls of Medicaid disabled. Several of the reasons for past growth (e.g., rising numbers of low-income families and increasing recognition of disabilities) seem likely to continue.

After accounting for the large increases in Medicaid enrollment, annual spending growth on a per enrollee basis was only 2.9 percent between 2000 and 2005 and 2.7 percent between 2006 and 2010. Per enrollee Medicaid spending growth is low in part because the growth in enrollment in adults and children has been faster than the growth in the aged and disabled, making the Medicaid population less costly on average. Growth in Medicaid enrollment of the aged and disabled stayed roughly constant at about 2.7 percent annually. Enrollment of children and families increased by 5.6 percent per year between 2000 and 2010.[31] We estimate that controlling for the composition shift would add about 1.5 percentage points to the growth in spending per enrollee.[32]

Compared to growth in GDP per capita, growth in Medicaid spending per enrollee was within approximately 1 percentage point over the last decade (not including the compositional shift). In the first half (2000–2005), per enrollee Medicaid spending grew at a rate of 1 percentage point below GDP per capita, while in the latter half it grew at a rate of 1.5 percentage points above GDP per capita (GDP grew very slowly because of the recession). These relatively low growth rates in Medicaid spending reflect a variety of factors: strong control over provider payment rates and benefits because of budget constraints from the two recessions, the growth of managed care, effective controls of prescription drug costs, and lower rates of institutionalization.[33]

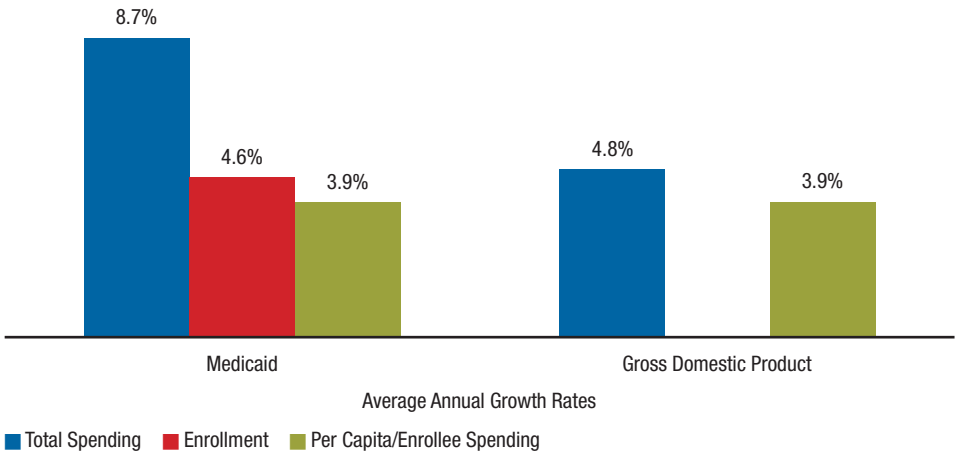
Medicaid Expenditures, 2011–2020

We now turn to Medicaid spending projections for the next decade. Figure 8 shows spending projections by CMS actuaries. According to CMS, Medicaid spending is projected to increase by 8.7 percent per year between 2011 and 2020. This reflects the large increase in Medicaid enrollment because of the ACA. Overall, Medicaid enrollment is projected to increase by an average of 4.6 percent per year. Thus, the increase in spending per enrollee projected by the actuaries is 3.9 percent, the same as the projected growth in GDP per capita. Part of this reflects the fact that the Medicaid expansion in the ACA makes the Medicaid population somewhat healthier, thus reducing the average cost of the Medicaid population. On the other hand, the effect of population aging (e.g., faster growth of the elderly population and greater use of long-term care by the growing 85+ population) increases spending per enrollee.[34] On balance, the 3.9 percent increase in spending per enrollee probably somewhat understates the increases in per enrollee spending because of the compositional shifts. But even with growth in spending per enrollee somewhat above 3.9 percent per year, this is not far above the growth in GDP per capita, also 3.9 percent per year. Again, states have strong incentives to control Medicaid spending, given their financial contributions and competing priorities.

CBO includes projections of the federal share of Medicaid spending growth between 2011 and 2020 in its March 2012 baseline. Figure 9 shows these projections, which suggest that federal Medicaid spending would increase from $251 billion in 2011 to $505 billion in 2020 (appendix table 4), an average annual increase of 8.1 percent. This increase in spending is less than that projected by CMS because the latter assumes a greater increase in enrollment in the ACA than does CBO. The increase in spending projected by CBO, however, overstates the underlying total growth in spending because CBO projects only federal spending, and that is affected upward by the high matching rate applied to newly eligible beneficiaries under the ACA.

CBO projects faster increases in expenditures for adults because of the large number of parents and childless adults to become eligible for Medicaid at the beginning of 2014 (Figure 10). Enrollment is projected to increase by 2.0 percent per year for the aged, 1.0 percent for the blind and disabled, and 1.3 percent

Figure 8: Medicaid Expenditure and Enrollment Projections, 2011-2020



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, August 2011.

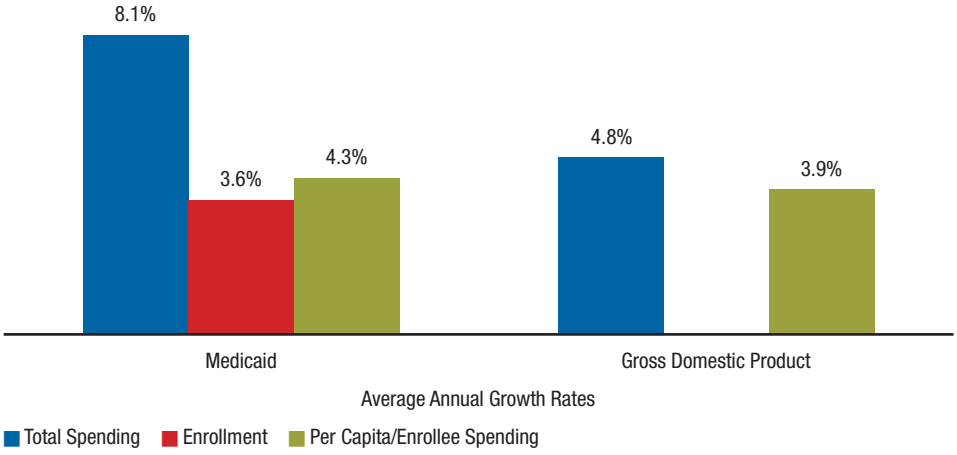
for children. Increases for adults average 8.3 percent per year, mostly because of the substantial jump at the implementation of the ACA. The average annual increase in Medicaid enrollment is projected to be 3.6 percent overall (figure 9).

Projected federal spending growth per enrollee averages about 4.3 percent per year, including an increase of 8.1 percent per year for the adult population. It is not clear whether the large growth in per enrollee spending for adults is primarily due to the higher federal match for the newly eligible population or if CBO assumes that this will be a more expensive adult population than Medicaid has historically served. Such an assumption about the health status of the newly eligible would be in contrast to the CMS actuaries' and our own analysis.[35] To estimate the real underlying rate of increase in spending per enrollee, we calculate the increase as if the growth per enrollee for adults were no different than the other groups. If spending per enrollee for the adult population had increased at the average of the other three groups, 4.3 percent per year, Medicaid spending per enrollee would have increased at 3.3 percent per year. As with the CMS projections, one reason for the 3.3 percent growth rate is the faster projected growth of a less expensive population. If we assume that distribution of enrollee types remains constant, however, the growth in spending per enrollee remains 4.3 percent per year, slightly above the increase in GDP per capita (3.9 percent).

To summarize:

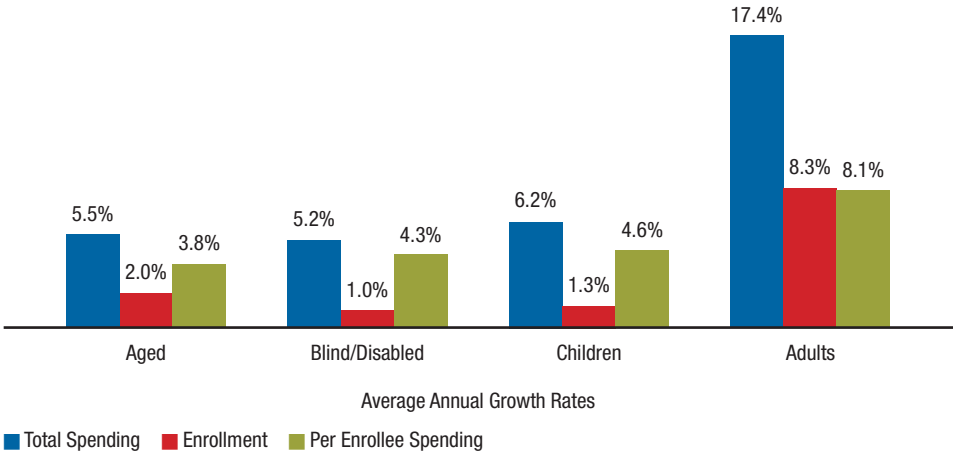
- As with private health insurance and Medicare spending, the rate of increase in Medicaid spending declined over the past decade.
- Medicaid expenditure growth has been greatly affected by enrollment growth caused by the two economic recessions over the past decade and continued growth in the disabled population.
- Spending on a per enrollee basis in the past decade was below 3.0 percent per year. One explanation is the changing composition of Medicaid enrollees toward a lower-cost group of enrollees. But aggressive cost containment efforts by states also contributed.

Figure 9: CBO Federal Medicaid Expenditure and Enrollment Projections, 2011-2020



Source: Congressional Budget Office March 2012 Medicaid Baseline.
Note: Per capita spending estimates are based on the cost of enrollees who receive full Medicaid benefits. Total spending and enrollment include enrollees who receive only partial benefits.

Figure 10: CBO Federal Medicaid Expenditure and Enrollment Projections, by Enrollee Category, 2011-2020



Source: Congressional Budget Office March 2012 Medicaid Baseline.
Note: Per capita spending estimates are based on the cost of enrollees who receive full Medicaid benefits. Total spending and enrollment include enrollees who receive only partial benefits.

- Overall Medicaid expenditures are projected to grow at 8.7 percent per year by the CMS actuaries and 8.1 percent per year by CBO between 2011 and 2020.
- Increases in overall Medicaid spending will continue to be driven by enrollment growth, largely because of the ACA.
- Both CMS and CBO project spending per enrollee in Medicaid to be slightly above 4.0 percent per year, only slightly faster than growth in GDP per capita.

Discussion

This paper has shown that a substantial share of the recent growth in Medicare and Medicaid spending has been due to enrollment growth and that CMS and CBO projections suggest this trend will continue. Growth in Medicare spending per enrollee was quite rapid at the beginning of the past decade but began to slow, particularly after 2007. The provisions of the ACA, as well as slower than expected underlying inflation rates,

are projected to reduce spending growth in Medicare considerably. Spending growth on a per enrollee basis is expected to be close to the growth in GDP per capita over the next decade, even after accounting for a likely fix for the SGR cuts. Medicaid spending growth has been held down by a variety of policies adopted by states facing severe fiscal constraints and has resulted in per enrollee spending that has been slower than the rate of growth in GDP in the past decade. Projections indicate only slightly faster growth in the coming decade. We have also shown that Medicare and Medicaid have had slower growth in expenditures on a per enrollee basis than private alternatives; a trend that is also projected to continue.

In the debate over the federal deficit, however, many have argued for the need for entitlement reforms to further reduce the rate of growth of spending on Medicare and Medicaid. Some proposals involve modest adjustments to the existing programs, but others call for more fundamental restructuring. A Medicare premium support program, for instance, would use federal funds to provide seniors with a voucher to purchase coverage in the private market; in some proposals, beneficiaries would continue to have traditional Medicare as a choice. Savings are achieved over time assuming that private insurance premiums are less expensive than Medicare and grow more slowly. This paper shows that any premium support program that accounted for the underlying enrollment growth projected for the Medicare program would have a hard time doing better than the current program at controlling spending growth. Proponents have suggested that the level of subsidies or vouchers would increase by at least the growth in GDP per capita or GDP per capita plus 1 percent.[36] But if the goal is to have Medicare spending per enrollee grow at the rate of GDP per capita, the projections by both CMS and CBO suggest that this will be achieved in the coming decade under current law.

Under a Medicaid block grant, the federal government would provide a fixed amount of funding to states to support their Medicaid programs, indexed to grow by a predetermined rate. Such a policy would have to accommodate projected enrollment growth, however, with federal payments growing in line with the growth in per capita GDP, unless the goal is to simply shift costs to the states. But as we have shown, Medicaid spending per enrollee is projected to grow at a rate very close to that of GDP per capita over the next decade.

Thus, changing Medicare to a program that is largely based on private insurers is unlikely to be the answer to Medicare's rising costs and will, in some versions, simply shift a substantial amount of spending onto Medicare beneficiaries. Similarly, states under a block grant are unlikely to be any more effective at containing overall Medicaid cost growth and will need to absorb more costs or shift burdens to program enrollees. States already have all the tools that would be available with the block grant, as well as strong financial incentives to control costs.

We have focused on the rate of growth in Medicare and Medicaid spending, but one could argue that the levels are higher than they otherwise should be. Studies that have compared Medicare and Medicaid spending to private insurance spending consistently show that expenditures in both programs are lower than private expenditures, however. For example, CBO has estimated that Medicare spending averages 11 percent less than a private insurance plan for the same package of benefits—Medicare has lower administrative costs and has lower payment rates than private payers.[37] MedPAC has shown that private plan bids are only slightly below traditional Medicare, but these data do not fully adjust for risk or for the fact that private plans disproportionately locate in the markets where traditional Medicare costs are highest.[38] How much these factors account for is unknown at this point. Research has also shown that Medicaid spending is lower than private spending, holding population characteristics constant.[39] This has also been shown for selected populations, such as the mentally ill and the chronically ill.[40]

The fact that expenditure growth in both programs is largely driven by enrollment growth does not mean that overall expenditures do not place heavy burdens on the federal budget; hence the need to look for policy options for reducing costs in both programs. The ACA includes several provisions to change the delivery system; time will tell how successful these will be. Meanwhile, CBO, MedPAC, the National Commission on Fiscal Responsibility and Reform, the Bipartisan Policy Center, and our earlier work have pointed to a range of options short of premium support.[41] Medicare savings can be achieved by increasing average Part B and Part D premiums in a way that would reduce them for low-income people but increase them for middle- and high-income people. CBO estimates savings of $241 billion over 10 years if Part B premiums were increased from 25 to 35 percent of premiums; savings would be less if low-income beneficiaries were protected.[42] CBO has estimated that copayments for home health services at 10 percent of the cost of home health episodes would bring in $50 billion over 10 years.[43]

Medicare cost-sharing could be restructured, with say a single deductible of $550 and a coinsurance rate of 20 percent for Parts A and B, with an out-of-pocket cap of $7,500. This would yield savings of $110 billion over 10 years.[44] Reforms to the Medigap market as proposed by the National Commission on Fiscal Responsibility and Reform that would prohibit covering the first $500 of cost-sharing and limit coverage to 50 percent of the next $5,000 would yield $38 billion.[45] Gradually raising the Medicare age of eligibility to 67 would yield $125 billion, net of new costs for federal Medicaid and low-income subsidies within exchanges.[46] Employer and state Medicaid expenditures would also increase, however, and this policy is only feasible after full implementation of the ACA.

Medicare could also benefit from having more money spent on administration to reduce the amount of fraud in the program more aggressively.[47] Requiring Medicaid drug rebates for all dual eligibles enrolled in Part D would yield $112 billion.[48] Reducing payment updates for home health agencies and skilled nursing facilities because of their high profit levels, as called for by MedPAC, would yield $40 billion.[49]

Policy choices that can reduce federal Medicaid spending include limits on use of provider taxes, from which CBO estimates savings of $44 billion. Provider taxes have grown to be a significant revenue source for states. They are a problem only if there is also an increase in payment rates to providers who directly or indirectly pay the tax. The result in such cases is to increase federal spending. Limits on provider taxes could yield significant federal savings, but would shift costs to states.[50] States could also adopt many of the payment and delivery system reforms being developed in Medicare and do more to address fraud and improper payments.[51] There are also potential savings from placing dual eligibles in care coordination programs that better manage their care. But most research shows that successful programs of this kind would provide far more savings to Medicare than to Medicaid. States in general have already adopted very aggressive cost-containment policies in Medicaid, which are reflected in the slow growth of spending per enrollee discussed above.

Historically, health care spending in both public and private programs has grown more than 2 percentage points faster than GDP growth. Michael Chernew and colleagues have shown that continued rates of increase at 2 percentage points faster than GDP will eventually reduce real consumption of other goods and services—more than 100 percent of all economic growth will be spent on health services.[52] They show that reducing health care spending growth closer to the increases in GDP plus 1 percent would permit increases in real nonhealth spending. This paper indicates that, after accounting for enrollment, both CMS and CBO project spending growth rates for Medicare and Medicaid over the next decade to be at or below the projected rate of growth in GDP per capita. Private spending growth per enrollee is projected to grow about 2 percentage points faster than Medicare, however. Thus, a major concern over the future course of Medicare and Medicaid spending growth is the rate of increase in private spending. It could be that more control over private spending is needed to ensure that the projections for Medicare and Medicaid are sustainable.

Appendix

Data and Methods

We present estimates from the CMS OACT of total health consumption expenditures, as well as estimates for Medicare, Medicaid, and private health insurance. Health consumption expenditures differ from total national health expenditures because they exclude spending on investments such as research and equipment. We do not present estimates for out-of-pocket spending or spending by other third-party payers, which reflect the balance of health consumption expenditures beyond Medicare, Medicaid, and private health insurance.

Enrollment estimates by coverage type come from a variety of sources. We obtain private insurance enrollment estimates from the 2000–2010 Current Population Surveys by calculating the number of individuals who report any employer-sponsored or private nongroup coverage at any time during a given year. Historic estimates of Medicare Part A and Part B enrollment are obtained from the CMS Medicare enrollment reports.[53] Medicare Part D enrollment is from the CMS Monthly Contract and Enrollment Summary reports.[54] Estimates of Medicaid enrollment were available from CMS OACT only for 2005–2010. We used the annual Medicaid enrollment growth rate from 2000–2005 from Health Management Associates enrollment estimates to generate estimates for 2000–2004.

We generate per capita spending estimates by dividing spending by enrollment for each payer in each year. For Medicare, we generate service-specific estimates of per capita spending. Estimates of per capita hospital, nursing facility, and administrative spending were generated by dividing spending by Part A enrollment. Per capita estimates of physician and other personal health care spending used Part B enrollment. Estimates of per capita spending on prescription drugs used Part A enrollment through 2005 and Part D enrollment thereafter. Total per capita Medicare spending is then calculated by summing the per capita spending on each service. By dividing total Medicare spending by this per capita estimate, we generate an average enrollment.

We present projections of health spending and enrollment for the period 2011–2020 from both CMS OACT and CBO, and use these to generate per capita spending estimates. Medicare projections from CBO include separate estimates for Part A, Part B, and Part D, so we calculate per capita spending estimates for each part and estimate total per capita Medicare spending as the sum of the per capita estimates for each part. We then generate a weighted average enrollment estimate by dividing total Medicare spending by the overall per capita spending estimate. CBO Medicaid projections include federal Medicaid spending only and provide separate estimates for aged, blind and disabled, and child and adult enrollees. Per capita spending estimates are provided for each enrollee group and are based on those enrollees who receive the full Medicaid benefits package, while total spending and enrollment estimates also include those who receive partial benefits. Thus, one cannot generate the provided per capita estimates by dividing total spending by total enrollment. In order to generate an estimate of overall Medicaid per capita spending, we use the average of the per capita estimates for each enrollee group weighted by their total enrollment.

Supplemental Tables

Appendix Table 1: Health Expenditure and Enrollment Estimates, by Payer, 2000-2010 (Total Expenditure and Coverage Estimates in Millions)

												Average Annual Growth Rate	
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2000-2005	2006-2010
Health Consumption Expenditures	1289639	1402842	1534372	1664333	1782640	1902639	2031468	2153447	2250141	2349544	2444600		
Growth Rate		8.8%	9.4%	8.5%	7.1%	6.7%	6.8%	6.0%	4.5%	4.4%	4.0%	8.1%	4.7%
Population	282.3	285.1	287.7	290.2	292.8	295.4	298.2	301.2	303.9	306.3	308.7		
Population Growth Rate		1.0%	0.9%	0.9%	0.9%	0.9%	0.9%	1.0%	0.9%	0.8%	0.8%	0.9%	0.9%
Per Capita Health Consumption Expenditures	4568	4921	5333	5735	6088	6441	6812	7150	7404	7671	7919		
Per Capita Growth Rate		7.7%	8.4%	7.5%	6.2%	5.8%	5.8%	4.9%	3.6%	3.6%	3.2%	7.1%	3.8%
Gross Domestic Product (Billions)	9952	10286	10642	11142	11853	12623	13377	14029	14292	13939	14527		
Growth Rate		3.4%	3.5%	4.7%	6.4%	6.5%	6.0%	4.9%	1.9%	-2.5%	4.2%	4.9%	2.1%
Per Capita GDP	35253	36079	36990	38394	40482	42732	44859	46577	47029	45508	47059		
Per Capita Growth Rate		2.3%	2.5%	3.8%	5.4%	5.6%	5.0%	3.8%	1.0%	-3.2%	3.4%	3.9%	1.2%
Private Health Insurance Spending	459633	503025	560460	614473	658911	702895	740167	776213	807627	828816	848701		
Growth Rate		9.4%	11.4%	9.6%	7.2%	6.7%	5.3%	4.9%	4.0%	2.6%	2.4%	8.9%	3.5%
Private Health Insurance Enrollment	205.1	203.7	203.7	201.5	202.6	202.8	203.6	203.4	202.2	195.8	195.5		
Enrollment Growth Rate		-0.7%	0.0%	-1.1%	0.5%	0.1%	0.4%	-0.1%	-0.6%	-3.2%	-0.2%	-0.2%	-1.0%
Per Enrollee Private Health Insurance Spending	2241	2469	2751	3049	3253	3467	3636	3815	3994	4233	4342		
Per Enrollee Growth Rate		10.2%	11.4%	10.8%	6.7%	6.6%	4.9%	4.9%	4.7%	6.0%	2.6%	9.1%	4.5%
Medicare Spending	224337	247115	264587	282011	310474	338772	403108	432258	466907	499771	524551		
Growth Rate		10.2%	7.1%	6.6%	10.1%	9.1%	19.0%	7.2%	8.0%	7.0%	5.0%	8.6%	6.8%
Medicare Enrollment	38.6	39.0	39.4	40.0	40.6	41.2	39.2	40.1	41.5	42.2	43.2		
Enrollment Growth Rate		1.0%	1.1%	1.4%	1.6%	1.5%	-4.8%	2.2%	3.5%	1.8%	2.3%	1.3%	2.5%
Per Enrollee Medicare Spending	5813	6340	6713	7057	7649	8220	10277	10779	11254	11831	12137		
Per Enrollee Growth Rate		9.1%	5.9%	5.1%	8.4%	7.5%	25.0%	4.9%	4.4%	5.1%	2.6%	7.2%	4.2%
Medicaid Spending	200483	224236	248218	269105	290917	309539	306840	326371	343814	374433	401418		
Growth Rate		11.8%	10.7%	8.4%	8.1%	6.4%	-0.9%	6.4%	5.3%	8.9%	7.2%	9.1%	6.9%
Medicaid Enrollment	34.1	36.7	40.1	42.3	44.2	45.6	45.6	45.6	47.1	50.6	53.7		
Enrollment Growth Rate		7.5%	9.3%	5.6%	4.3%	3.2%	0.0%	0.0%	3.3%	7.4%	6.1%	6.0%	4.2%
Per Enrollee Medicaid Spending	5878	6115	6192	6355	6586	6788	6729	7157	7300	7400	7475		
Per Enrollee Growth Rate		4.0%	1.3%	2.6%	3.6%	3.1%	-0.9%	6.4%	2.0%	1.4%	1.0%	2.9%	2.7%

Sources: Centers for Medicare and Medicaid Services, Office of the Actuary, January 2012; Current Population Survey 2000-2010; CMS Part A and B Enrollment reports and Part D Contract and Enrollment Summary Reports.
Notes: The sum of Medicare, Medicaid and private health insurance expenditures does not equal total health consumption expenditures. Health consumption expenditures also includes out of pocket spending and spending by other third party payers.

Appendix Table 2: Health Expenditure and Enrollment Projections, by Payer, 2011-2020 (Total Expenditure and Coverage Estimates in Millions)

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Average Annual Growth Rate 2011-2020
Health Consumption Expenditures	2540807	2646942	2792619	3027554	3204431	3404106	3605336	3818232	4065639	4337702	
Growth Rate		4.2%	5.5%	8.4%	5.8%	6.2%	5.9%	5.9%	6.5%	6.7%	6.1%
Population	313.2	316	318.8	321.6	324.4	327.2	330	332.8	335.6	338.4	
Population Growth Rate		0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.8%	0.8%	0.8%	0.9%
Per Capita Health Consumption Expenditures	8112	8376	8760	9414	9878	10404	10925	11473	12115	12818	
Per Capita Growth Rate		3.3%	4.6%	7.5%	4.9%	5.3%	5.0%	5.0%	5.6%	5.8%	5.2%
Gross Domestic Product (Billions)	15334	16071	16891	17804	18712	19574	20455	21396	22381	23388	
Growth Rate		4.8%	5.1%	5.4%	5.1%	4.6%	4.5%	4.6%	4.6%	4.5%	4.8%
Per Capita GDP	48959	50858	52983	55361	57682	59823	61985	64291	66690	69113	
Per Capita Growth Rate		3.9%	4.2%	4.5%	4.2%	3.7%	3.6%	3.7%	3.7%	3.6%	3.9%
Private Health Insurance Spending	850303	884405	926882	1013655	1076748	1141025	1200332	1250951	1324726	1401999	
Growth Rate		4.0%	4.8%	9.4%	6.2%	6.0%	5.2%	4.2%	5.9%	5.8%	5.7%
Private Health Insurance Enrollment	184.7	186.3	188	192.3	194.9	195	196.8	196.8	197.4	197.8	
Enrollment Growth Rate		0.9%	0.9%	2.3%	1.4%	0.1%	0.9%	0.0%	0.3%	0.2%	0.8%
Per Enrollee Private Health Insurance Spending	4604	4747	4930	5271	5525	5851	6099	6356	6711	7088	
Per Enrollee Growth Rate		3.1%	3.9%	6.9%	4.8%	5.9%	4.2%	4.2%	5.6%	5.6%	4.9%
Medicare Spending	556093	565592	599546	636802	668083	707376	751157	801257	857378	921964	
Growth Rate		1.7%	6.0%	6.2%	4.9%	5.9%	6.2%	6.7%	7.0%	7.5%	5.8%
Medicare Enrollment	47.9	49.3	50.9	52.4	53.9	55.4	57.1	58.8	60.5	62.3	
Enrollment Growth Rate		2.9%	3.2%	2.9%	2.9%	2.8%	3.1%	3.0%	2.9%	3.0%	3.0%
Per Enrollee Medicare Spending	11609	11472	11779	12153	12395	12769	13155	13627	14172	14799	
Per Enrollee Growth Rate		-1.2%	2.7%	3.2%	2.0%	3.0%	3.0%	3.6%	4.0%	4.4%	2.7%
Medicaid Spending	428105	456827	487773	586835	630858	684637	732158	783795	841922	908061	
Growth Rate		6.7%	6.8%	20.3%	7.5%	8.5%	6.9%	7.1%	7.4%	7.9%	8.7%
Medicaid Enrollment	55.5	56.2	56.3	75.6	77.8	80.6	81.4	82.3	82.9	83.5	
Enrollment Growth Rate		1.3%	0.2%	34.3%	2.9%	3.6%	1.0%	1.1%	0.7%	0.7%	4.6%
Per Enrollee Medicaid Spending	7714	8129	8664	7762	8109	8494	8995	9524	10156	10875	
Per Enrollee Growth Rate		5.4%	6.6%	-10.4%	4.5%	4.8%	5.9%	5.9%	6.6%	7.1%	3.9%

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, August 2011.
Notes: The sum of Medicare, Medicaid and private health insurance expenditures does not equal total health consumption expenditures. Health consumption expenditures also includes out of pocket spending and spending by other third party payers.

Appendix Table 3: CBO Medicare Expenditure and Enrollment Projections, 2011-2020

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Average Annual Growth Rate (2011-2020)
Medicare Spending (Billions)	556.7	566.7	601.3	630.2	658.4	714.7	739.3	769.7	840.5	898.2	
Growth Rate		1.8%	6.1%	4.8%	4.5%	8.6%	3.4%	4.1%	9.2%	6.9%	5.5%
Medicare Enrollment (Millions)	45.0	46.8	48.3	49.7	51.1	52.4	53.9	55.5	56.9	58.5	
Enrollment Growth Rate		4.0%	3.1%	2.9%	2.8%	2.6%	2.9%	3.0%	2.5%	2.8%	2.9%
Per Enrollee Medicare Spending	12361	12105	12459	12684	12886	13638	13710	13858	14764	15355	
Per Enrollee Growth Rate		-2.1%	2.9%	1.8%	1.6%	5.8%	0.5%	1.1%	6.5%	4.0%	2.4%
Medicare Part A Spending (Billions)	260.2	264	282.4	297.9	305.5	324.1	332.2	344.7	366.8	386.3	
Growth Rate		1.5%	7.0%	5.5%	2.6%	6.1%	2.5%	3.8%	6.4%	5.3%	4.5%
Medicare Part A Enrollment (Millions)	48.4	50.1	51.7	53.3	54.9	56.4	58	59.6	61.3	63	
Enrollment Growth Rate		3.5%	3.2%	3.1%	3.0%	2.7%	2.8%	2.8%	2.9%	2.8%	3.0%
Per Enrollee Part A Spending	5376	5269	5462	5589	5565	5746	5728	5784	5984	6132	
Per Enrollee Growth Rate		-2.0%	3.7%	2.3%	-0.4%	3.3%	-0.3%	1.0%	3.5%	2.5%	1.5%
Medicare Part B Spending (Billions)	230.7	242.6	247.8	254.1	266.9	288.2	301.5	317.1	344.2	368.9	
Growth Rate		5.2%	2.1%	2.5%	5.0%	8.0%	4.6%	5.2%	8.5%	7.2%	5.4%
Medicare Part B Enrollment (Millions)	45	46.4	47.9	49.3	50.7	52.2	53.7	55.3	56.8	58.4	
Enrollment Growth Rate		3.1%	3.2%	2.9%	2.8%	3.0%	2.9%	3.0%	2.7%	2.8%	2.9%
Per Enrollee Part B Spending	5127	5228	5173	5154	5264	5521	5615	5734	6060	6317	
Per Enrollee Growth Rate		2.0%	-1.1%	-0.4%	2.1%	4.9%	1.7%	2.1%	5.7%	4.2%	2.3%
Medicare Part D Spending (Billions)	65.8	60.1	71.1	78.2	86	102.4	105.6	107.9	129.5	143	
Growth Rate		-8.7%	18.3%	10.0%	10.0%	19.1%	3.1%	2.2%	20.0%	10.4%	9.0%
Medicare Part D Enrollment (Millions)	35.4	37.4	39	40.3	41.8	43.2	44.6	46.1	47.6	49.2	
Enrollment Growth Rate		5.6%	4.3%	3.3%	3.7%	3.3%	3.2%	3.4%	3.3%	3.4%	3.7%
Per Enrollee Part D Spending	1859	1607	1823	1940	2057	2370	2368	2341	2721	2907	
Per Enrollee Growth Rate		-13.5%	13.4%	6.4%	6.0%	15.2%	-0.1%	-1.1%	16.2%	6.8%	5.1%

Source: Congressional Budget Office March 2012 Medicare baseline.

Appendix Table 4: CBO Federal Medicaid Expenditure and Enrollment Projections, 2011-2020

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Average Annual Growth Rate (2011-2020)
Federal Medicaid Spending (Billions)	251	233	249	309	354	392	419	443	475	505	
Growth Rate		-7.2%	6.9%	24.1%	14.6%	10.7%	6.9%	5.7%	7.2%	6.3%	8.1%
Medicaid Enrollment (Millions)	67	68	68	79	86	91	91	91	92	92	
Enrollment Growth Rate		1.5%	0.0%	16.2%	8.9%	5.8%	0.0%	0.0%	1.1%	0.0%	3.6%
Per Enrollee Federal Medicaid Spending	4130	3894	4254	4436	4627	4856	5119	5407	5724	6041	
Per Enrollee Growth Rate		-5.7%	9.2%	4.3%	4.3%	5.0%	5.4%	5.6%	5.9%	5.5%	4.3%
Federal Medicaid Spending - Aged (Billions)	50	46	48	51	55	59	64	69	75	81	
Growth Rate		-8.0%	4.3%	6.3%	7.8%	7.3%	8.5%	7.8%	8.7%	8.0%	5.5%
Medicaid Enrollment - Aged (Millions)	5	6	6	6	6	6	6	6	6	6	
Enrollment Growth Rate		20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.0%
Per Enrollee Federal Medicaid Spending - Aged	12380	11341	11840	12448	13123	13933	14716	15553	16471	17389	
Per Enrollee Growth Rate		-8.4%	4.4%	5.1%	5.4%	6.2%	5.6%	5.7%	5.9%	5.6%	3.8%
Federal Medicaid Spending - Blind/Disabled (Billions)	110	102	110	119	127	135	144	153	164	174	
Growth Rate		-7.3%	7.8%	8.2%	6.7%	6.3%	6.7%	6.3%	7.2%	6.1%	5.2%
Medicaid Enrollment-Blind/Disabled (Millions)	11	11	12	12	12	12	12	12	12	12	
Enrollment Growth Rate		0.0%	9.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%
Per Enrollee Federal Medicaid Spending - Blind/Disabled	10735	9743	10255	10863	11502	12270	13048	13869	14754	15703	
Per Enrollee Growth Rate		-9.2%	5.3%	5.9%	5.9%	6.7%	6.3%	6.3%	6.4%	6.4%	4.3%
Federal Medicaid Spending - Children (Billions)	54	50	54	63	68	73	77	81	87	93	
Growth Rate		-7.4%	8.0%	16.7%	7.9%	7.4%	5.5%	5.2%	7.4%	6.9%	6.2%
Medicaid Enrollment - Children (Millions)	33	33	33	35	36	37	37	37	37	37	
Enrollment Growth Rate		0.0%	0.0%	6.1%	2.9%	2.8%	0.0%	0.0%	0.0%	0.0%	1.3%
Per Enrollee Federal Medicaid Spending - Children	1694	1553	1704	1845	1936	2037	2138	2259	2400	2541	
Per Enrollee Growth Rate		-8.3%	9.7%	8.3%	4.9%	5.2%	5.0%	5.7%	6.2%	5.9%	4.6%
Federal Medicaid Spending - Adults (Billions)	37	35	37	76	104	125	134	140	149	157	
Growth Rate		-5.4%	5.7%	105.4%	36.8%	20.2%	7.2%	4.5%	6.4%	5.4%	17.4%
Medicaid Enrollment - Adults (Millions)	18	18	17	26	32	36	36	36	37	37	
Enrollment Growth Rate		0.0%	-5.6%	52.9%	23.1%	12.5%	0.0%	0.0%	2.8%	0.0%	8.3%
Per Enrollee Federal Medicaid Spending - Adults	2268	2130	2289	3109	3482	3769	3940	4131	4376	4568	
Per Enrollee Growth Rate		-6.1%	7.5%	35.8%	12.0%	8.2%	4.5%	4.8%	5.9%	4.4%	8.1%

Source: Congressional Budget Office March 2012 Medicaid Baseline.
Note: Per enrollee spending estimates are based on the cost of enrollees who receive the full Medicaid benefits package, while total spending and enrollment estimates include enrollees who receive only partial benefits. Thus, the per enrollee estimates in this table cannot be generated from the total spending and enrollment estimates.

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